FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0023770

Facility Name: ST MARTHA MANOR

Address: 4621 RACINE AVENUE (Number) CHICAGO (City) 60640 (Zip Code)

County: COOK

Telephone Number: (773) 784-2300 **Fax #** (773) 769-4621

IDPA ID Number: 362944224001

Date of Initial License for Current Owners: 12/01/77

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) JEFFREY K. SINGER, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	57	Skilled (SNF)	57	20,805	1
2		Skilled Pediatric (SNF/PED)			2
3	75	Intermediate (ICF)	75	27,375	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	132	TOTALS	132	48,180	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,275			3,275	8
9	SNF/PED					9
10	ICF	41,311	137	188	41,636	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,586	137	188	44,911	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.22%

D. How many bed-hold days during this year were paid by Public Aid?
409 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1/1/1978

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/1/1978 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	165,182	29,532	38,834	233,548		233,548	(408)	233,140			1
2	Food Purchase		366,206		366,206	(34,120)	332,086	(11)	332,075			2
3	Housekeeping	86,212	50,471	192,785	329,468		329,468	(205)	329,263			3
4	Laundry		16,104	8,406	24,510		24,510		24,510			4
5	Heat and Other Utilities			106,114	106,114		106,114	4,468	110,582			5
6	Maintenance	92,720		108,854	201,574		201,574	(30,024)	171,550			6
7	Other (specify):*											7
8	TOTAL General Services	344,114	462,313	454,993	1,261,420	(34,120)	1,227,300	(26,180)	1,201,120			8
	B. Health Care and Programs											
9	Medical Director			6,816	6,816		6,816		6,816			9
10	Nursing and Medical Records	1,032,420	122,982	355,263	1,510,665		1,510,665	(2,777)	1,507,888			10
10a	Therapy			10,207	10,207		10,207		10,207			10a
11	Activities	34,389	21,646	147,370	203,405		203,405	(107)	203,298			11
12	Social Services	39,604		29,109	68,713		68,713		68,713			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,106,413	144,628	548,765	1,799,806		1,799,806	(2,884)	1,796,922			16
	C. General Administration											
17	Administrative	148,241		486,000	634,241		634,241	(520,708)	113,533			17
18	Directors Fees											18
19	Professional Services			17,213	17,213		17,213	6,162	23,375			19
20	Dues, Fees, Subscriptions & Promotions			15,204	15,204		15,204	(636)	14,568			20
21	Clerical & General Office Expenses	30,460	65,812	83,953	180,225		180,225	132,387	312,612			21
22	Employee Benefits & Payroll Taxes			207,690	207,690	34,120	241,810	(1,021)	240,789			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,209	2,209		2,209	117	2,326			24
25	Other Admin. Staff Transportation			663	663		663	2,701	3,364			25
26	Insurance-Prop.Liab.Malpractice			90,907	90,907		90,907	3,216	94,123			26
27	Other (specify):*							39,407	39,407			27
28	TOTAL General Administration	178,701	65,812	903,839	1,148,352	34,120	1,182,472	(338,375)	844,097			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,629,228	672,753	1,907,597	4,209,578		4,209,578	(367,439)	3,842,139			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number ST MARTHA MANOR #0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			64,582	64,582		64,582	44,671	109,253			30
31	Amortization of Pre-Op. & Org.							1,711	1,711			31
32	Interest			2,256	2,256		2,256	97,249	99,505			32
33	Real Estate Taxes			98,163	98,163		98,163	8,726	106,889			33
34	Rent-Facility & Grounds			240,000	240,000		240,000	(240,000)				34
35	Rent-Equipment & Vehicles			16,057	16,057		16,057		16,057			35
36	Other (specify):*							(3,222)	(3,222)			36
37	**TOTAL Ownership**			421,058	421,058		421,058	(90,865)	330,193			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			45,956	45,956		45,956	(7,674)	38,282			41
42	Provider Participation Fee			72,270	72,270		72,270		72,270			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			118,226	118,226		118,226	(7,674)	110,552			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,629,228	672,753	2,446,881	4,748,862		4,748,862	(465,978)	4,282,884			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(18,351)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(11)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(6,775)	21		18
19	Entertainment				19
20	Contributions	(723)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(351)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,133)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(178,898)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (206,242)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(259,736)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (259,736)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (465,978)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

ST MARTHA MANOR

ID# 0023770

Report Period Beginning: 01/01/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	VENDING INCOME	$ (7,674)	41	1
2	MISCELLANEOUS EXPENSE	(143)	21	2
3	TRAFFIC VIOLATIONS	(231)	21	3
4	TAX PENALTY	(354)	21	4
5	MISCELLANEOUS INCOME	(80)	21	5
6	PPA-RN SALARIES	(541)	10	6
7	PPA - LPN SALARIES	(809)	10	7
8	PPA- NURSE AIDE SALARIES	(1,427)	10	8
9	PPA-PAYROLL TAXES	(1,021)	22	9
10	PPA-DIETARY SALARIES	(408)	01	10
11	PPA-MAINTENANCE SALARIES	(50)	06	11
12	PPA-HOUSKEEPING SALARIES	(205)	03	12
13	PPA-ACTIVITIES SALAIRES	(107)	11	13
14	PPA-OFFICE SALARIES	(56)	21	14
15	PPA-SECURITY SALARIES	(186)	06	15
16	NON-ALLOWABLE FEES	(489)	20	16
17	MARKETING TRAVEL	(628)	25	17
18	NON-ALLOWABLE REAL ESTATE	(6,190)	33	18
19	BLDG COMPANY OFFICE EXPENSE	(100)	21	19
20	CAPITALIZED R&M	(34,898)	6	20
21	NON-CARE ASSET DEPRECIATION	(1,475)	20	21
22	BANK CHARGES	(26,826)	21	22
23	BUILDING COMPANY MANAGEMENT FEE	(95,000)	17	23
24				24
25				25
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100				100
101	Total	(178,898)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(408)											(408)	1
2	Food Purchase	(11)											(11)	2
3	Housekeeping	(205)											(205)	3
4	Laundry													4
5	Heat and Other Utilities			1,553		2,915							4,468	5
6	Maintenance	(35,134)		5,110									(30,024)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(35,758)		6,663		2,915							(26,180)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(2,777)											(2,777)	10
10a	Therapy													10a
11	Activities	(107)											(107)	11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(2,884)											(2,884)	16
	C. General Administration													
17	Administrative	(95,000)		(486,000)	22,792	37,500							(520,708)	17
18	Directors Fees													18
19	Professional Services			6,162									6,162	19
20	Fees, Subscriptions & Promotions	(1,563)		927									(636)	20
21	Clerical & General Office Expenses	(35,698)	100	90,705		77,280							132,387	21
22	Employee Benefits & Payroll Taxes	(1,021)											(1,021)	22
23	Inservice Training & Education													23
24	Travel and Seminar			117									117	24
25	Other Admin. Staff Transportation	(628)		3,329									2,701	25
26	Insurance-Prop.Liab.Malpractice			3,216									3,216	26
27	Other (specify):*			15,187	4,483	19,737							39,407	27
28	**TOTAL General Administration**	(133,910)	100	(366,357)	27,275	134,517							(338,375)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(172,552)	100	(359,694)	27,275	137,432							(367,439)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ST MARTHA MANOR # 0023770 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(19,826)	59,793	3,622		1,082							44,671	30
31	Amortization of Pre-Op. & Org.		1,711										1,711	31
32	Interest		78,375	18,874									97,249	32
33	Real Estate Taxes	(6,190)	10,491	2,568		1,857							8,726	33
34	Rent-Facility & Grounds		(240,000)										(240,000)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*		(3,222)										(3,222)	36
37	**TOTAL Ownership**	(26,016)	(92,852)	25,064		2,939							(90,865)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops	(7,674)											(7,674)	41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**	(7,674)											(7,674)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(206,242)	(92,752)	(334,630)	27,275	140,371							(465,978)	45

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
PETER O'BRIEN	60.00%	SEE ATTACHED		SEE ATTACHED		
DANIEL O'BRIEN	20.00%					
MARY O'BRIEN	20.00%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENTAL INCOME	$ 240,000	PROPERTY ACCOUNT 4621	100.00%	$	$ (240,000)	1
2	V	21	OFFICE EXPENSE				100	100	2
3	V	30	DEPRECIATION				59,793	59,793	3
4	V	33	REAL ESTATE TAXES				10,491	10,491	4
5	V	17	MANGEMENT FEE	95,000			95,000		5
6	V	31	AMORTIZATION				1,711	1,711	6
7	V	32	INTEREST				78,375	78,375	7
8	V	36	OTHER				(3,222)	(3,222)	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 335,000			$ 242,248	$ * (92,752)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	MADO MGMT. LP	100.00%	$ 1,553	$ 1,553	15
16	V	6	REPAIRS AND MAINT.				5,110	5,110	16
17	V	19	PROFESSIONAL FEES				6,162	6,162	17
18	V	20	DUES AND SUBSCRIPTIONS				927	927	18
19	V	21	CLERICAL AND GENERAL				90,705	90,705	19
20	V	24	SEMINARS				117	117	20
21	V	25	AUTO EXPENSE				3,329	3,329	21
22	V	26	PROPERTY INSURANCE				3,216	3,216	22
23	V	27	GEN. ADMIN. - EMP. BEN.				15,187	15,187	23
24	V	30	DEPRECIATION				3,622	3,622	24
25	V	32	INTEREST				18,874	18,874	25
26	V	33	REAL ESTATE TAXES				2,568	2,568	26
27	V								27
28	V								28
29	V	17	MANAGEMENT FEES	486,000				(486,000)	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 486,000			$ 151,370	$ * (334,630)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	SALARY-D. O'BRIEN	$	MADO MGMT. LP	100.00%	$ 3,125	$ 3,125	15
16	V	27	EMP. BEN.-D. O'BRIEN				1,570	1,570	16
17	V								17
18	V	17	SALARY-P. O'BRIEN				16,667	16,667	18
19	V	27	EMP. BEN.-P. O'BRIEN				2,455	2,455	19
20	V								20
21	V	17	SALARY-C. STUMPF				3,000	3,000	21
22	V	27	EMP. BEN.-C. STUMPF				458	458	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 27,275	$ * 27,275	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	MADO MGMT. LP	100.00%	$ 2,915	$ 2,915	15
16	V	6	REPAIRS AND MAINTENANCE						16
17	V	17	ADMINISTRATIVE SALARY				37,500	37,500	17
18	V	21	CLERICAL SALARY				77,280	77,280	18
19	V	27	GEN. ADMIN. - EMP. BEN.				19,737	19,737	19
20	V	30	DEPRECIATION-WAREHOUSE				1,082	1,082	20
21	V	33	REAL ESTATE TAXES				1,857	1,857	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 140,371	$ * 140,371	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$ 35,146	WINDY CITY NURSING	100.00%	$ 35,146	$	15
16	V	3	HOUSEKEEPING	192,785			192,785		16
17	V	4	LAUNDRY	8,406			8,406		17
18	V	6	MAINTENANCE	5,629			5,629		18
19	V	11	ACTIVITIES	142,356			142,356		19
20	V	12	SOCIAL SERVICES	25,389			25,389		20
21	V	21	OFFICE	77,984			77,984		21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 487,695			$ 487,695	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING SUPPLIES	$ 6,449	ST. AGNES MEDICAL EQUIPMENT	100.00%	$ 6,449	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 6,449			$ 6,449	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	DANIEL O'BRIEN	OWNER	ADMIN	20.00%	SEE ATTACHED	3	7.50%	SALARY	$ 125,000	17-1	1
2	DANIEL O'BRIEN	OWNER	ADMIN	20.00%	SEE ATTACHED	3	7.50%	Alloc.Salary	3,125	17-7	2
3	PETER O'BRIEN	OWNER	ADMIN	60.00%	SEE ATTACHED	6	10.00%	Alloc.Salary	16,667	17-7	3
4	CHARLES STUMPF	RELATIVE	ADMIN	0	SEE ATTACHED	2	4.44%	Alloc.Salary	3,000	17-7	4
5	KATHLEEN STUMPF	RELATIVE	ADMIN	0	SEE ATTACHED	35	77.78%	Alloc.Salary	37,500	17-7	5
6	JAMES WEST	RELATIVE	CLERICAL	0	SEE ATTACHED	7.6	19.00%	Alloc.Salary	10,497	21-7	6
7	BRIDGET STUMPF	RELATIVE	CLERICAL	0	NONE	40	100.00%	Alloc.Salary	62,280	21-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 258,069		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MADO MGMT. LP
Street Address: 1541 N. WELLS ST.
City / State / Zip Code: CHICAGO, IL. 60610
Phone Number: (312) 787-9400
Fax Number: (312) 787-9434

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	235,319	5	$ 8,137	$	44,911	$ 1,553	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	235,319	5	26,777		44,911	5,110	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	235,319	5	32,288		44,911	6,162	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	235,319	5	4,856		44,911	927	4
5	21	CLERICAL AND GENERAL	PATIENT DAYS	235,319	5	475,262	393,151	44,911	90,705	5
6	24	SEMINARS	PATIENT DAYS	235,319	5	613		44,911	117	6
7	25	AUTO EXPENSE	PATIENT DAYS	235,319	5	17,441		44,911	3,329	7
8	26	PROPERTY INSURANCE	PATIENT DAYS	235,319	5	16,851		44,911	3,216	8
9	27	GEN. ADMIN. - EMP. BEN.	PATIENT DAYS	235,319	5	79,574		44,911	15,187	9
10	30	DEPRECIATION	PATIENT DAYS	235,319	5	18,981		44,911	3,622	10
11	32	INTEREST	PATIENT DAYS	235,319	5	98,891		44,911	18,874	11
12	33	REAL ESTATE TAXES	PATIENT DAYS	235,319	5	13,454		44,911	2,568	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 793,125	$ 393,151		$ 151,370	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MADO MGMT. LP
Street Address: 1541 N. WELLS ST.
City / State / Zip Code: CHICAGO, IL. 60610
Phone Number: (312) 787-9400
Fax Number: (312) 787-9434

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	SALARY-D. O'BRIEN	AVG. HRS WORKED	24	5	25,000	25,000	3	3,125	1
2	27	EMP. BEN.-D. O'BRIEN	AVG. HRS WORKED	24	5	12,558		3	1,570	2
3										3
4	17	SALARY-P. O'BRIEN	AVG. HRS WORKED	45	5	125,000	125,000	6	16,667	4
5	27	EMP. BEN.-P. O'BRIEN	AVG. HRS WORKED	45	5	18,409		6	2,455	5
6										6
7	17	SALARY-C. STUMPF	AVG. HRS WORKED	45	5	67,500	67,500	2	3,000	7
8	27	EMP. BEN.-C. STUMPF	AVG. HRS WORKED	45	5	10,311		2	458	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 258,778	$ 217,500		$ 27,275	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MADO MGMT. LP
Street Address: 1541 N. WELLS ST.
City / State / Zip Code: CHICAGO, IL. 60610
Phone Number: (312) 787-9400
Fax Number: (312) 787-9434

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	DIRECT ALLOC		1	2,915			2,915	1
2	6	REPAIRS AND MAINTENANCE	DIRECT ALLOC		1					2
3	17	ADMINISTRATIVE SALARY	DIRECT ALLOC		5	255,302	255,302		37,500	3
4	21	CLERICAL SALARY	DIRECT ALLOC		2	218,362	218,362		77,280	4
5	27	GEN. ADMIN. - EMP. BEN.	DIRECT ALLOC		5	68,636			19,737	5
6	30	DEPRECIATION-WAREHOUSE	DIRECT ALLOC		1	1,082			1,082	6
7	33	REAL ESTATE TAXES	DIRECT ALLOC		1	1,857			1,857	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 548,154	$ 473,664		$ 140,371	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: WINDY CITY NURSING
Street Address: 1541 N. WELLS
City / State / Zip Code: CHICAGO, IL 60690
Phone Number: (312) 787-9400
Fax Number: (312) 787-9434

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	DIRECT ALLOC			$	$		$ 35,146	1
2	3	HOUSEKEEPING	DIRECT ALLOC						192,785	2
3	4	LAUNDRY	DIRECT ALLOC						8,406	3
4	6	MAINTENANCE	DIRECT ALLOC						5,629	4
5	11	ACTIVITIES	DIRECT ALLOC						142,356	5
6	12	SOCIAL SERVICES	DIRECT ALLOC						25,389	6
7	21	OFFICE	DIRECT ALLOC						77,984	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 487,695	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ST. AGNES MEDICAL EQUIPMENT
Street Address: 1541 N WELLS
City / State / Zip Code: CHICAGO, IL 60610
Phone Number: (312) 787-9400
Fax Number: (312) 787-9434

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING SUPPLIES	DIRECT ALLOC			$	$		$ 6,449	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 6,449	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	4621 BUILDING CORP	X		MORTGAGE	$16,355.00	12/28/98	$ 1,100,000	$ 990,291	12/31/08		$ 78,375	1
2												2
3												3
4												4
5												5
	Working Capital											
6	TIFCO		X	INSURANCE FINANCING							2,256	6
7												7
8												8
9	TOTAL Facility Related				$16,355.00		$ 1,100,000	$ 990,291			$ 80,631	9
	B. Non-Facility Related*											
10	See Supplemental Schedule											10
11	ALLOC. MADO MGMT										18,874	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 18,874	14
15	TOTALS (line 9+line14)						$ 1,100,000	$ 990,291			$ 99,505	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 0 Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$	21

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 108,311	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 104,072	2
3. Under or (over) accrual (line 2 minus line 1).		$ (4,239)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 111,129	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 106,890	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	93,832	8
	1998	99,879	9
	1999	99,209	10
	2000	92,929	11
	2001	99,647	12

ACCRUAL = 2001 TAX x 1.11
99647 x 1.11 = 111129
ALLOCATED FROM MADO $4425

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ST MARTHA MANOR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0023770

CONTACT PERSON REGARDING THIS REPORT STEVEN LAVENDA

TELEPHONE 847-236-1111 FAX #: 847-236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-17-207-006-0000	LONG TERM CARE PROPERTY	$ 94,546.83	$ 94,546.83
2.	14-17-207-012-0000	LONG TERM CARE PROPERTY	$ 799.35	$ 799.35
3.	14-17-207-013-0000	LONG TERM CARE PROPERTY	$ 1,478.94	$ 1,478.94
4.	14-14-207-014-0000	LONG TERM CARE PROPERTY	$ 6,189.52	$ 6,189.52
5.	14-17-207-019-0000	LONG TERM CARE PROPERTY	$ 2,822.12	$ 2,822.12
6.	17-04-204-012-0000	HOME OFFICE ALLOCATION	$ 13,454.36	$ 2,567.79
7.	14-17-207-014-0000	HOME OFFICE ALLOCATION	$ 6,189.52	$ 1,856.86
8.		BILL COUNTED TWICE	$ (6,189.52)	$ (6,189.52)
9.			$	$
10.			$	$
		TOTALS	$ 119,291.12	$ 104,071.89

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ST MARTHA MANOR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0023770

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 35,364 B. General Construction Type: Exterior _____ Frame FIRE RETARDENT Number of Stories 6

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: 1,711 4. Dates Incurred: 1995, 1998

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	12,868	1984	$ 70,700	1
2					2
3	TOTALS	12,868		$ 70,700	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4				1984	$ 1,494,824	$ 59,793	35	$ 49,827	$ (9,966)	$ 857,440	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1978	541		20	-		541	9
10	Various			1979	38,105		20	-		38,105	10
11	Various			1981	22,244		20	-		22,244	11
12	Various			1982	12,527		20	-		12,527	12
13	Various			1983	5,530		20	-		5,530	13
14	Various			1984	25,958		20	-		25,958	14
15	Various			1985	10,641		20	-		10,641	15
16	Various			1986	13,635		20	682	682	6,820	16
17	Various			1987	65,231		20	-		65,231	17
18	Various			1988	30,395		20	(140)	(140)	30,255	18
19	Various			1990	115,949		20	5,107	5,107	77,142	19
20	Various			1991	10,000		20	500	500	3,162	20
21	Various			1992	22,069		20	1,104	1,104	18,163	21
22	Various			1993	18,217		20	883	883	12,044	22
23	Various			1994	12,220		20	611	611	5,499	23
24	Various			1995	109,219		20	5,355	5,355	47,810	24
25	Various			1996	28,361		20	1,418	1,418	9,645	25
26	Various			1997	69,848		20	3,759	3,759	21,027	26
27	Various			1998	56,951		20	2,851	2,851	12,870	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		82,662	3,130		2,857	(273)	20,199	68
69	Financial Statement Depreciation			40,111			(40,111)		69
70	TOTAL (lines 4 thru 69)		$ 2,245,127	$ 103,034		$ 74,814	$ (28,220)	$ 1,302,853	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,245,127	$ 103,034		$ 74,814	$ (28,220)	$ 1,302,853	1
2	HAND RAILINGS	1999	1,650		20	83	83	332	2
3	METAL DOORS	1999	1,975		20	99	99	396	3
4	FLOORING	1999	2,536		20	127	127	508	4
5	FLOOING	1999	2,341		20	117	117	468	5
6	METAL DOORS	1999	844		20	42	42	165	6
7	ALUMINUM FRAME DOOR	1999	7,000		20	350	350	1,371	7
8	FLOORING	1999	589		20	29	29	114	8
9	CERAMIC FLOORING	1999	5,905		20	295	295	1,131	9
10	BLINDS	1999	531		20	27	27	104	10
11	BLINDS	1999	828		20	41	41	147	11
12	CONCRETE WALK	1999	16,500		20	825	825	2,819	12
13	5 STEEL DOORS	1999	6,375		20	319	319	1,090	13
14	30 NEW DOOR CLOSURE	1999	2,050		20	103	103	343	14
15	10 BATHROOMS	1999	7,700		20	385	385	1,283	15
16	FIREPROOFING OF BLDG	1999	1,995		20	100	100	392	16
17	NEW ROOF-KITCHEN	1999	1,600		20	80	80	307	17
18	DECORATING	1999	1,203		20	60	60	220	18
19	DECORATING	1999	2,820		20	141	141	505	19
20	PAINT & DECOR	1999	828		20	41	41	164	20
21	WALL CABINETS	1999	3,163		20	158	158	579	21
22	24 GAUGE PREFIN.PANE	1999	7,312		20	366	366	1,251	22
23	FLOORING	1999	1,563		20	78	78	273	23
24	PAINT & DECOR	1999	649		20	32	32	112	24
25	PAINT & DECOR	1999	567		20	28	28	93	25
26	NEW COMPRESSOR	1999	925		20	46	46	161	26
27	LANDSCAPING	1999	1,425		20	71	71	243	27
28	LANDSCAPING	1999	3,000		20	150	150	513	28
29	LANDSCAPING	1999	1,000		20	50	50	167	29
30	LANDSCAPING	1999	1,810		20	91	91	303	30
31	LANDSCAPING	1999	825		20	41	41	137	31
32	KITCHEN REPAIR	1999	1,800		20	90	90	285	32
33	LAUNDRY CEILING REPA	1999	600		20	30	30	95	33
34	TOTAL (lines 1 thru 33)		$ 2,335,036	$ 103,034		$ 79,309	$ (23,725)	$ 1,318,924	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,335,036	$ 103,034		$ 79,309	$ (23,725)	$ 1,318,924	1
2	KITCHEN REPAIR	1999	600		20	30	30	95	2
3	KITCHEN REPAIR	1999	1,100		20	55	55	170	3
4	DOOR HINGES	1999	1,429		20	71	71	213	4
5	PIPE INSTALLATION	2000	2,383		20	119	119	327	5
6	PLUMBING WORK	2000	2,038		20	102	102	272	6
7	DOORS & FRAMES	2000	3,083		20	154	154	462	7
8	SPRINKLER	2000	948		20	47	47	141	8
9	FIRE PUMP REP	2000	1,094		20	55	55	147	9
10	SMOKE DETECTOR/WRNG	2000	590		20	30	30	85	10
11	ELEVATOR REPAIRS	2000	799		20	40	40	110	11
12	ELEVATOR REPAIRS	2000	1,259		20	63	63	147	12
13	ELEVATOR REP	2000	1,279		20	64	64	155	13
14	ELEVATOR REP	2000	8,175		20	409	409	1,193	14
15	ELEVATOR REP	2000	1,241		20	62	62	176	15
16	FIRE ALARM PAVEL	2000	2,136		20	107	107	241	16
17	TILE	2000	2,893		20	145	145	387	17
18	COUNTER TOPS	2000	2,055		20	103	103	258	18
19	BOILER INSTALL	2000	18,885		20	944	944	2,203	19
20	OIL PRESSURE SWITCH	2000	1,675		20	84	84	189	20
21	STEAM TRAPS/VALVES	2000	1,314		20	66	66	193	21
22	3/4 PUMPMOTOR"	2000	1,107		20	55	55	165	22
23	A/C MODIFICATION	2000	1,505		20	75	75	200	23
24	ALARM SYSTEM	2000	639		20	32	32	91	24
25	ALARM SYSTEM	2000	683		20	34	34	79	25
26	BRICK WALLS	2000	12,200		20	610	610	1,322	26
27	CEMENT WORK	2000	3,390		20	170	170	383	27
28	DOOR SAFETY LOCK	2000	2,350		20	118	118	246	28
29	METER GUAGE	2000	1,173		20	59	59	148	29
30	ALARM SYSTEM	2000	584		20	29	29	82	30
31	LANDSCAPING	2000	1,099		20	55	55	147	31
32	SINK	2000	687		20	34	34	88	32
33	ALLEY DOOR	2000	640		20	32	32	83	33
34	TOTAL (lines 1 thru 33)		$ 2,416,069	$ 103,034		$ 83,362	$ (19,672)	$ 1,329,122	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,416,069	$ 103,034		$ 83,362	$ (19,672)	$ 1,329,122	1
2	SPRINKLER SYSTEM	2000	562		20	28	28	68	2
3	SIDE RAILS	2000	775		20	39	39	94	3
4	TOILETS	2000	1,025		20	51	51	119	4
5	WATER FLOW SWITCH	2000	761		20	38	38	86	5
6	BOILER HEAD	2000	705		20	35	35	79	6
7	MINI BLINDS	2000	2,390		20	120	120	250	7
8	SINK REPAIR	2000	550		20	28	28	58	8
9	WALK-IN FREEZER	2001	679		20	34	34	40	9
10	DOOR LOCKS	2001	2,340		20	117	117	195	10
11	TAMPER PANEL	2001	4,505		20	225	225	450	11
12	AIR CLEANER	2001	1,845		20	92	92	184	12
13	IRON GATE	2001	2,350		20	118	118	177	13
14	IRON FENCE	2001	925		20	46	46	54	14
15	GENERATOR	2001	39,875		20	1,994	1,994	3,157	15
16	RETAINER WALL	2001	6,740		20	337	337	506	16
17	ELEVATOR REPAIRS	2001	1,464		20	73	73	110	17
18	FENCE	2001	748		20	37	37	65	18
19	FENCE REPAIRS	2001	1,575		20	79	79	145	19
20	FIRE ESCAPE REPAIRS	2001	700		20	35	35	58	20
21	GATE	2001	1,525		20	76	76	114	21
22	PUMP REPAIRS	2001	1,018		20	51	51	98	22
23	MOTOR	2001	780		20	39	39	75	23
24	WALL GUARDS	2001	738		20	37	37	68	24
25	CORNER GUARDS	2001	1,159		20	58	58	68	25
26	PIPE REPAIRS	2001	643		20	32	32	61	26
27	LANDSCAPING	2001	815		20	41	41	58	27
28	WIRING	2001	1,172		20	59	59	69	28
29	CALL LIGHT SYSTEM	2001	798		20	40	40	43	29
30	RADIATOR CABINETS	2002	7,128		20	713	713	713	30
31	FIRE ALARM PULL STATION	2002	3,519		20	176	176	176	31
32	VERTICAL BLINDS	2002	975		20	49	49	49	32
33	RADIATOR COVERS	2002	8,401		20	840	840	840	33
34	TOTAL (lines 1 thru 33)		$ 2,515,254	$ 103,034		$ 89,099	$ (13,935)	$ 1,337,449	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 2,515,254	$ 103,034		$ 89,099	$ (13,935)	$ 1,337,449	1
2	WATER HEATER	2002	4,385		20	219	219	219	2
3	EXHAUST FAN	2002	4,380		20	219	219	219	3
4	HYDRAULIC PUMP	2002	8,175		20	409	409	409	4
5	BRICKS AND WALLS	2002	38,800		20	1,940	1,940	1,940	5
6	ROOM RENOVATIONS	2002	8,507		20	425	425	425	6
7	CUBICLE CURTAINS	2002	4,931		20	247	247	247	7
8	VALVE REPAIRS	2002	1,365		20	68	68	68	8
9	GUTTER REPAIRS	2002	5,400		20	270	270	270	9
10	WINDOWS	2002	1,836		20	92	92	92	10
11	CONCRETE WORK	2002	1,600		20	80	80	80	11
12	ELEVATOR REPAIRS	2002	1,054		20	53	53	53	12
13	AC REPAIRS	2002	2,705		20	135	135	135	13
14	TUCKPOINTING	2002	10,000		20	500	500	500	14
15	OFFICE RENOVATIONS	2002	942		20	47	47	47	15
16	SPRINKLER REPAIRS	2002	930		20	47	47	47	16
17	AWNING REPAIRS	2002	650		20	33	33	33	17
18	TUCKPOINTING	2002	1,800		20	90	90	90	18
19	HEAT EXCHANGER	2002	2,595		20	130	130	130	19
20	ELEVATOR REPAIRS	2002	924		20	46	46	46	20
21	BATHROOM REPAIRS	2002	686		20	34	34	34	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,616,919	$ 103,034		$ 94,182	$ (8,852)	$ 1,342,532	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 2,616,919	$ 103,034		$ 94,182	$ (8,852)	$ 1,342,532	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,616,919	$ 103,034		$ 94,182	$ (8,852)	$ 1,342,532	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 2,616,919	$ 103,034		$ 94,182	$ (8,852)	$ 1,342,532	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,616,919	$ 103,034		$ 94,182	$ (8,852)	$ 1,342,532	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 2,616,919	$ 103,034		$ 94,182	$ (8,852)	$ 1,342,532	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,616,919	$ 103,034		$ 94,182	$ (8,852)	$ 1,342,532	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 2,616,919	$ 103,034		$ 94,182	$ (8,852)	$ 1,342,532	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,616,919	$ 103,034		$ 94,182	$ (8,852)	$ 1,342,532	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 2,616,919	$ 103,034		$ 94,182	$ (8,852)	$ 1,342,532	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,616,919	$ 103,034		$ 94,182	$ (8,852)	$ 1,342,532	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 2,616,919	$ 103,034		$ 94,182	$ (8,852)	$ 1,342,532	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,616,919	$ 103,034		$ 94,182	$ (8,852)	$ 1,342,532	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1988	1988	$ 39,559	$ 1,438	35	$ 1,130	$ (308)	$ 7,912	4
5			1985	1985	21,630	1,082	35	618	(464)	4,326	5
6											6
7											7
8											8
	Improvement Type**										
9	ALLOCATED FROM MADO MANAGEMENT			1993	15,068	401	20	753	352	7,100	9
10	ALLOCATED FROM MADO MANAGEMENT			1995	918	183	20	46	(137)	345	10
11	ALLOCATED FROM MADO MANAGEMENT			2000	2,253	-	20	113	113	284	11
12	ALLOCATED FROM MADO MANAGEMENT			2001	976	26	20	49	(23)	84	12
13	ALLOCATED FROM MADO MANAGEMENT			2002	2,258	-	20	148	148	148	13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 82,662	$ 3,130		$ 2,857	$ (319)	$ 20,199	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 154,437	$ 7,464	$ 9,610	$ 2,146	10	$ 111,309	71
72	Current Year Purchases	4,374	15,332	462	(14,870)	10	462	72
73	Fully Depreciated Assets	130,613				10	130,613	73
74								74
75	TOTALS	$ 289,424	$ 22,796	$ 10,072	$ (12,724)		$ 242,384	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1988 MERCEDES	1988	$	$	$	$		$	76
77		BMW	1998	25,000	1,775	5,000	3,225	5	22,500	77
78		BMW	1998							78
79										79
80	TOTALS			$ 25,000	$ 1,775	$ 5,000	$ 3,225		$ 22,500	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,002,043	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 127,605	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 109,254	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (18,351)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,607,416	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	1988 MERCEDES - 1988	$ 54,359	$ 1,475	$ 54,359	86
87	BMW - 1998	18,000		18,000	87
88					88
89					89
90					90
91	TOTALS	$ 72,359	$ 1,475	$ 72,359	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 16,057 Description: SEE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	N/A	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,554	$ 2,284	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	869,078	884,309	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	24,665	24,665	6
7	Other Prepaid Expenses	37	37	7
8	Accounts Receivable (owners or related parties)	4,144,806	5,357,315	8
9	Other(specify): See Supplemental Schedule	10,300	10,300	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 5,050,440	$ 6,278,910	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost		70,700	14
15	Leasehold Improvements, at Historical Cost	968,475	2,463,299	15
16	Equipment, at Historical Cost	396,671	396,671	16
17	Accumulated Depreciation (book methods)	(805,864)	(2,300,687)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		17,111	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(6,844)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule	3,100	3,100	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 562,382	$ 643,350	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,612,822	$ 6,922,260	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 978,885	$ 1,393,886	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	72,502	72,502	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	111,129	111,129	32
33	Accrued Interest Payable		9,000	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	1,212,535	1,212,535	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,375,051	$ 2,799,052	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		990,291	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 990,291	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,375,051	$ 3,789,343	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,237,771	$ 3,132,917	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,612,822	$ 6,922,260	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,518,686	1	
2	Restatements (describe):		2	
3			3	
4	INCOME RESTATEMENT	(7,700)	4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,510,986	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(273,215)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (273,215)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,237,771	24	*

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,467,893	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,467,893	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	7,674	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 7,674	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Supplemental Schedule	80	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 80	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,475,647	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,261,420	31
32	Health Care	1,799,806	32
33	General Administration	1,148,352	33
	B. Capital Expense		
34	Ownership	421,058	34
	C. Ancillary Expense		
35	Special Cost Centers	45,956	35
36	Provider Participation Fee	72,270	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,748,862	40
41	**Income before Income Taxes (line 30 minus line 40)****	(273,215)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (273,215)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,685	10,984	265,458	24.17	3
4	Licensed Practical Nurses	13,907	14,836	249,767	16.84	4
5	Nurse Aides & Orderlies	59,092	62,882	517,195	8.22	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,955	2,091	22,402	10.71	9
10	Activity Assistants	1,332	1,406	11,987	8.53	10
11	Social Service Workers	4,797	4,884	39,604	8.11	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,549	24,933	165,182	6.63	15
16	Dishwashers					16
17	Maintenance Workers	11,952	12,784	92,720	7.25	17
18	Housekeepers	11,282	12,285	86,212	7.02	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator	998	998	23,241	23.29	21
22	Other Administrative	156	156	125,000	801.28	22
23	Office Manager					23
24	Clerical	1,642	1,745	30,460	17.46	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	141,347	149,984	$ 1,629,228 *	$ 10.86	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	148	$ 3,688	01-03	35
36	Medical Director	96	6,816	09-03	36
37	Medical Records Consultant	MONTHLY	4,128	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	235	10,207	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	96	5,014	11-03	44
45	Social Service Consultant	69	3,720	12-03	45
46	Other(specify)				46
47	SEE ATTACHED		202,891		47
48					48
49	TOTAL (lines 35 - 48)	644	$ 236,464		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	6,290	$ 275,262	10-03	50
51	Licensed Practical Nurses	3,012	75,873	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	9,302	$ 351,135		53

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
DANIEL O'BRIEN	ADMINISTRATIVE	20%	$ 125,000
LEA RADUNSKY	ASST. ADMIN	0	23,241
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 148,241

B. Administrative - Other

Description	Amount
MANAGEMENT FEES - MADO MANAGEMENT	$ 486,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 486,000

C. Professional Services

Vendor/Payee	Type	Amount
FR&R	ACCOUNTING	$ 7,953
WOLF & CO	ACCOUNTING	3,618
PERSONNEL PLANNERS	UNEMPLOYMENT CONS	1,194
RENITH VILORIA	ACCOUNTING	575
HEALTH DATA SYSTEMS	DATA PROCESSING	3,873
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 17,213

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 15,635
Unemployment Compensation Insurance	6,082
FICA Taxes	124,636
Employee Health Insurance	59,827
Employee Meals	34,120
Illinois Municipal Retirement Fund (IMRF)*	
401K	489
TOTAL (agree to Schedule V, line 22, col.8)	$ 240,789

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	8,072
Health Care Worker Background Check	2,380
(Indicate # of checks performed 220)	
LICENSES AND FEES	2,681
DUES	108
ADVERTISING AND PROMOR	351
ALLOC MADO	927
Less: Public Relations Expense	( )
Non-allowable advertising	(351)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,568

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,209
ALLOC MADO MANAGEMENT	117
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,326

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number ST MARTHA MANOR # 0023770 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount. _____

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **28,882** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **72,270**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **34,120** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **At nsg home mgm co.**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees